**State of Iowa**
**Department of Education**
**IOWA VOCATIONAL REHABILITATION SERVICES**

RE: _____
NAME *(Typed or Printed )*

_____
DATE OF BIRTH *and/or* OTHER IDENTIFIER

## AUTHORITY FOR RELEASE AND EXCHANGE OF INFORMATION

**TO:**

Iowa Vocational Rehabilitation Services
510 E. 12th Street
Des Moines, IA 50319

I, the undersigned, hereby authorize you to disclose and deliver to:

**THE FOLLOWING SPECIFIC INFORMATION APPROXIMATE DATE OF REPORT(S): _____**

_____ Medical: Evaluation and/or Treatment Reports
_____ Hospital: Admitting History/Exam, Consultant Exam and Discharge Summary
_____ Psychiatric: Discharge Summary Letters and Clinical Notes
_____ Psychological: Evaluation and/or Treatment Reports
_____ Transcript of Grades or other Performance Report
_____ Other _____

I understand that the information you release will be used as appropriate and necessary in the determination of eligibility for, and the development of a program of rehabilitation services; or

_____

_____

I understand that the information may be given verbally or in written form and this release includes permission to furnish copies. I understand a copy of this form will accompany any written information released and I will also receive a copy at the time of disclosure. This form will also be kept in my VR casefile. I understand that I may review the disclosed information by contacting the person, agency, or individual releasing the information. I understand that the information will be used for purposes relating to my rehabilitation programming, and will not be released to any other agency, individual or organization for any other purpose without my written permission except as required by Federal or State Law. I understand that any action on my part to deny access to information that is essential to my rehabilitation programming may result in delaying or stopping rehabilitation services. I also understand that I may withdraw this permission at any time by sending written notice to the Iowa Vocational Rehabilitation Services, 510 East 12th Street, Des Moines, Iowa 50319. If I do so, I know that it cannot apply to any information that has been given before IVRS has received my written withdrawal and notified the supplier named above. In the absence of any withdrawal, or special instructions below, **this release will automatically expire 12 months from the date of my signature.**

Restrictions and/or Comments: _____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION
PROTECTED BY STATE OR FEDERAL LAW:

I SPECIFICALLY AUTHORIZE THE RELEASE OF DATA AND INFORMATION RELATING TO: *(Client must check appropriate box[es])*

| | YES | NO |
|---|---|---|
| 1. SUBSTANCE ABUSE | ☐ | ☐ |
| 2. MENTAL HEALTH | ☐ | ☐ |
| 3. HIV-RELATED INFORMATION | ☐ | ☐ |

_____ _____
*SIGNATURE OF CLIENT OR LEGAL GUARDIAN* *DATE*

**In order for the above information to be released, you must sign here AND to the right.**

_____ _____
CLIENT SIGNATURE DATE SIGNED

_____
STREET/P.O. BOX

_____
CITY/STATE/ZIP

_____
PARENT/GUARDIAN IF CLIENT IS A MINOR

_____
SIGNATURE OF WITNESS

For Responding Agency Use Only:

_____Staff Initial _____Date Released _____Date Copy Sent to Client